Nurse Practitioner Agreement

In providing care to Priority Health Members, I,_____ , agree to the following:

- ☐ I agree to maintain a collaborating physician relationship with the following physician(s)_____
- ☐ I agree to abide by the Priority Health Acceptance/Continued Participation Criteria (see attached Appendix B-1); specifically, I agree to 1) maintain a collaborative relationship with a Priority Health participating Physician who is trained in a primary care specialty, and 2) make appropriate referral or consultation of any Priority Health Member who has a diagnosis listed in Appendix B-1 on attached criteria.
- ☐ I agree to 1) maintain a copy of all privilege delineation lists or job descriptions from any Priority Health Participating Hospitals at which I maintain privileges, 2) forward to Priority Health a copy of each signed agreement I maintain with any Priority Health Primary Care Physician, and 3) forward to Priority Health a copy of any clinical protocols or other documented agreement used by me when caring for Priority Health Members.
- ☐ I agree to immediately notify Priority Health in the event the scope or nature of my professional affiliation with my Collaborative Physician changes.
- ☐ I agree to stay within the scope of the above criteria and understand that deviation from this Agreement may result in my termination from the Priority Health panel of providers.
- ☐ I understand my age panel will be consistent with my Collaborative Physician(s).
- ☐ I understand that Priority Health will triennially contact both me and my Collaborative Physician(s) to renew this agreement, unless otherwise notified.

Signature, Nurse Practitioner Date

Collaborative Physician Agreement

In providing care to Priority Health Members, I, _____ **,** agree to collaborate with: _____

- ☐ I confirm that I am the Collaborating Primary Care Physician for the above-named Nurse Practitioner.
- ☐ I agree to abide by all bylaws, rules and regulations, including policies and procedures governing the collaboration of Nurse Practitioners at Priority Health Participating Hospitals.
- ☐ I agree to inform Priority Health in the event I have concerns with regard to the quality of care provided by the Collaborative Nurse Practitioner.
- ☐ I agree to immediately notify Priority Health in the event the scope or nature of my professional affiliation with the Collaborative Nurse Practitioner changes.
- ☐ I agree to comply with all regulations of the State Medical Board and the Michigan Revised Code with respect to my supervision of the Collaborative Nurse Practitioner.

Signature, Collaborative Physician Date

PriorityHealth

PHYSICIAN ACKNOWLEDGEMENT OF
ACCOUNTABLE CARE ORGANIZATION (ACO) PARTICIPATION AGREEMENT

The undersigned physician hereby certifies as follows:

1. I am a member in good standing of the _____ (ACO).

2. I am duly licensed to practice medicine in the State of Michigan.

3. All information provided to Priority Health; Priority Health Managed Benefits, Inc.; Priority Health Government Programs; or Priority Health Insurance Company (collectively "Priority Health") with respect to my qualifications is accurate and complete.

4. I agree that Priority Health together with authorized regulatory agencies may inspect, review and copy records or reports in my possession concerning services provided to Members.

5. I agree to comply with Priority Health's quality assurance activities.

6. I agree to comply with the Medicare requirements listed in Attachment A, if the Medicare product is indicated below in section 8.

7. I agree to look solely to Priority Health for payment of services rendered pursuant to the Agreement (defined below). I further agree not to bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge, or have any recourse against a Member or persons acting on behalf of a Member, with respect to Covered Services provided to a Member, except to the extent that the applicable Plan specifies a copayment or deductible or as permitted under the Coordination of Benefits Act. I further agree not to maintain any action at law or in equity against a Member to collect sums that are owed to me under the terms of the Agreement, even if Priority Health fails to pay, becomes insolvent, or otherwise breaches the terms and conditions of the Agreement. This section will survive termination of the Agreement, regardless of the cause of termination and will be construed to be for the benefit of Members. The parties do not intend this section to apply to the collection of sums that are owed to me for services provided after the Agreement has terminated, except as otherwise provided in the Agreement, or to services that are not Covered Services or to copayments, coinsurance or deductibles. I further agree that this provision supersedes any oral or written agreement hereinafter entered into between me and a Member or a person acting on Member's behalf, insofar as such agreement relates to payment for services provided under the terms and conditions of the Agreement.

8. I agree to all of the terms and conditions of the ACO Participation Agreement(s) between Priority Health and ACO with respect to the following products: HMO☐, PPO☐, Medicaid☐, Medicare☐, and MIChild ☐ (the "Agreement"). Capitalized terms used herein and not otherwise defined carry the meanings given them in the Agreement.

Date: _____ By: _____

Print Name: _____

Medicare Number: _____

PriorityHealth

ATTACHMENT A

1. Activities and Responsibilities of Physician. Physician shall provide services as described in the Agreement.

2. Hold Harmless. Group Physician agrees that it, he or she will hold Members harmless from payment obligations that are the legal obligation of Priority Health and shall not look to Members for payment for Covered Services rendered to a Member.

(a) Physicians agree not to bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge, attempt in any way to hold a Member liable or have any recourse against a Member or persons acting on behalf of Member for payment of any fees for covered services that are the responsibility of Priority Health, except to the extent that the Plan specifies a copayment, coinsurance or deductible or as permitted under Coordination of Benefits statutes, rules, and regulations. Members shall not have copayments or other cost-sharing imposed upon them for influenza or pneumococcal vaccine Covered Services.

(b) Physician agrees not to maintain any action at law or in equity against a Member to collect sums that are owed to Physician under the terms of this Agreement, even in the event Priority Health fails to pay, becomes insolvent, or otherwise breaches the terms and conditions of this Agreement. This section will survive termination of this Agreement, regardless of the cause of termination and will be construed to be for the benefit of Members. Physician further agrees that this provision supersedes any oral or written agreement hereinafter entered into between Physician and Member or person acting on Member's behalf, insofar as such agreement relates to payment for services provided under the terms and conditions of this Agreement.

(c) Physician agrees not to charge Members for services other than Covered Services unless:

(i) the Member has been informed in writing prior to receiving the services that the services are not covered under the Plan, and

(ii) the Member has agreed in writing to pay for such services on such forms as may be required by Priority Health from time to time.

3. Record Keeping. Physician will maintain medical, financial, and administrative records concerning Covered Services provided to Members and will keep these records for at least 10 years from the date Physician rendered the Covered Services.

(a) Physician shall maintain such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under this Amendment. Physician will make available to Plan and CMS, or their designees, all records, including without limitation, prescription dispensing records, reports of service plan reports or complaints, grievances, quality and utilization data for fiscal audit, quality, utilization and risk management, and other periodic

monitoring upon request of authorized representatives of Plan and authorized federal and state regulating agencies.

(b) Physician agrees that pursuant to 42 CFR 422.504(i)(2)(i) and (ii), CMS, HHS, the Comptroller General, or their designees (the "Entities") may audit, evaluate or inspect any books, contracts, medical records, documents, papers, patient care records, and other records of Physician, any treating entity, contractor, subcontractor, or transferee that pertains to any aspect of the services performed under this Agreement, reconciliation of benefit liabilities and determination of amounts payable, or as the Entities may deem necessary (the "Treatment Records"). The right of the Entities to audit, evaluate, and inspect extends ten (10) years after termination of the CMS Contract and this Agreement or the completion of an audit, whichever is later. Physician agrees to make available its physical premises, facilities, equipment, and all Treatment Records or additional information the Entities may require.

(c) Physician agrees to safeguard Member privacy and confidentiality and assure the accuracy of Member health records, according to 42 CFR 504(a)13. Physician shall safeguard the privacy and security of Member information and records as required by federal and state law and regulations, including the applicable provisions of the Health Insurance Portability and Accountability Act ("HIPAA"), which require reasonable administrative, technical, and physical safeguards to ensure the integrity and confidentiality of Member information. Physician will only use and release such information to third parties in accordance with HIPAA and applicable federal and state statutes, rules, and guidance or pursuant to court order or subpoena. Physician shall have procedures that specify for what purposes Member information will be used by Physician and to whom and for what purposes Physician will disclose Member information. Physician acknowledges that no formal consent is necessary for Physician to provide information to Priority Health for purposes of payment, treatment, or healthcare operations.

(d) Physician shall grant Members access to their records in accordance with applicable state and federal law, including right to review, request to amend, and obtain a copy.

(e) Physician acknowledges that the CMS Contract requires Plan to submit to CMS all data necessary to characterize the context and purposes of each encounter between a Member and Physician, to certify the accuracy, completeness, and truthfulness of such data, and submit prescription records for validation of any such data. Physician agrees to cooperate with and assist Plan in meeting this requirement under the CMS Contract. Physician agrees that each time it submits a claim to Plan for services rendered hereunder, Physician is certifying the accuracy, completeness, and truthfulness of the claim. Physician agrees to submit records to Plan, CMS, or their designees if requested to validate any claims submitted and being adjudicated.

4. Delegation. Physician agrees not to delegate any professional duties to any other provider without the prior written approval of Priority Health. According to 42 CFR 422.504 (i)(3)(iii), Physician acknowledges and agrees that any services or other activity performed by a

related entity, contractor or subcontractor in accordance with a written agreement with Physician will be consistent and comply with Priority Health's obligations under the CMS Contract..

5. Prompt Payment. For timely submitted clean claims, Priority Health will make or deny payment within thirty (30) days. Such thirty (30) day time period will begin when Priority Health receives a Clean Claim from Physician or Physician's agent, including all required supporting documentation. Plan will reimburse Physician at the applicable rates as set forth in the Agreement's Exhibit A.

6. Compliance With Laws. The parties acknowledge and agree that payments received under this Agreement are, in whole or in part, federal funds. As a recipient of federal funds, Physician shall comply with all applicable state and federal laws, rules, and regulations in effect or as hereinafter amended applicable to recipients of federal funds including the following: (a) Title VI of the Federal Civil Rights Act; (b) Section 403 of the Federal Rehabilitation Act of 1973; (c) the Federal Age Discrimination Act of 1975; (d) Titles I and II of the Federal Americans with Disabilities Act; (e) Section 542 of the Federal Public Health Service Act (pertaining to nondiscrimination against substance abusers); (f) 45 CFR part 46, pertaining to research involving human subjects; and (g) all Medicare laws, regulations and CMS instructions according to 42 CFR 422.504(i)(4)(v). Both parties agree to comply with all state and federal laws, rules, and regulations applicable to the provision of Covered Services to Members. Plan oversees and is accountable to CMS for any functions or responsibilities that are described in 42 CFR 422.502.

7. Accountability. Plan oversees and is accountable to CMS for any functions or responsibilities that are described in 42 CFR 422.502.

8. Reporting Requirements. Physician understands that the Plan is required by CMS to maintain a health information system that collects, analyzes and integrates all data necessary to compile, evaluate and report certain statistical data, including encounter data. Physician agrees to submit all complete and accurate data necessary for the Plan to fulfill their obligations within the timeframes as specified by the Plan.

9. Benefit Continuation. In the event of termination of this Agreement Priority Health shall arrange for, and Physician shall cooperate with, the orderly transfer of all Members then under the care of the Physician:

(a) At Priority Health's option Physician will continue to provide Covered Services to Members who are in Active Treatment at the time of termination until the "End Date", which shall be the date upon which both: (i) the Member is no longer in Active Treatment; and (ii) Priority Health assigns such Members to another Participating Provider. For purposes of this Section, a Member shall be considered to be in "Active Treatment" if he or she is: (a) hospitalized; (b) undergoing treatment; or (c) in the second or third trimester of pregnancy through the completion of normal post-partum care. Both parties will comply with the terms of this Agreement while the Member is in Active Treatment until the End Date, except that Priority Health shall compensate Physician in accordance with the standard Original Medicare rates, or an amount agreed to by both parties. Physician shall notify affected Members and/or their employer groups of termination and obligations of Physician following termination as described in this Section.

(b) Upon termination, Physician shall promptly supply to Priority Health all information necessary for the reimbursement of any outstanding claims.

(c) Upon termination, Physician shall continue to provide Covered Services to Members until the end of the period for which Priority Health has received premiums from CMS.

(d) In the event of the insolvency of Priority Health, Physician shall continue to provide Covered Services to hospitalized Members through discharge.

10. Exclusion of Services. Physician has not been excluded from any federal healthcare program, and has not opted out of Medicare. Physician shall not employ or contract with any individual who is excluded from participation in the Medicare program, and acknowledges and agrees that Priority Health may immediately terminate this Agreement should Physician or any employee, contractor, or agent of Physician lose Medicare certification or be excluded or otherwise fail to participate in the Medicare program.

PriorityHealth

November 15th, 2017

Dear Dr. Provider:

We're committed to processing all of your reimbursements and other fund settlements properly. Because many of our programs with shared savings and risk sharing are settled at the physician organization level, **it's important for you to know which primary contractual relationship you are currently associated with.** This has no bearing on your actual membership within multiple groups.

We recently received a contract acknowledgement signed by you to participate with Priority Health via our agreement with ***Oakwood ACO***. However, our records indicated you are already a participating physician through our agreement with ***Current Primary Affiliation.***

If there needs to be a change in your primary physician organization affiliation, complete the below and send the information back to us so we can update our records. Otherwise, your primary affiliation will remain unchanged with ***Current Primary Affiliation***. Please note that you may change your contractual relationship only once per year.

Thanks for taking time to provide this information. If you have questions, please visit our website to identify your Provider Network Performance staff member at priorityhealth.com/provider/contact-us/representatives.

Sincerely,
Provider Network Performance Department

Return via email or fax to: PH-PELC@priorityhealth.com or 616.975.8857

I elect Oakwood ACO as my primary physician organization affiliation for reimbursement and fund settlement purposes.

_____ _____

Signature Date

_____

Printed name

Credentialing supplemental information

PriorityHealth

Personal information

Name (last, first, middle)	Degree (Degree/Professional title)
Other names you may have used (Maiden, A.K.A. etc.)	Date of birth (Month/day/year)
Gender ☐ Male ☐ Female	Ethnicity (Optional)
Social Security (optional)	
Type 1 (individual) NPI number	NPI taxonomy type
Tax ID	CAQH provider ID

Priority Health contracts (primary care providers only)

HMO and PPO (choose one)	☐ Accepting new patients	☐ Accepting established patients only
Medicaid and MIChild (choose one)	☐ Accepting new patients	☐ Accepting established patients only
Medicare (choose one)	☐ Accepting new patients	☐ Accepting established patients only

Hospital choice (primary care providers only)

Primary hospital affiliation _____

Scope of practice

How will you be seeing our members? In office, in hospital

Primary care physician (PCP)		Specialist (SCP)	Hospital-based/Hospitalist
☐ Family practice ☐ Family practice with deliveries ☐ General practice* ☐ Geriatric medicine ☐ Gynecology	☐ Internal medicine ☐ Internal medicine/pediatrics ☐ Ob/Gyn ☐ Pediatrics	_____ (Specialty or sub-specialty)	_____ (Specialty or sub-specialty)

*NPs/PA-Cs require submission of Collaborating Physician Form

Credentialing contact/office manager

Office contact	Email address
Address	City, state, ZIP
Telephone	Fax

mailing address

Primary and mailing office practice information

Primary office

Type of practice:

- ☑ Corporation
- ☐ Solo
- ☐ Hospital-based
- ☐ Rural/federal qualified health clinic
- ☐ Partnership
- ☐ Institution
- ☐ Hospital-employed

Type 2 (organization) NPI number	NPI taxonomy type

pay to:

Group practice name as it appears on Line 1 of W-9		
DBA (doing business as) name		
Address	Suite	City, state, ZIP
Telephone		Fax
Office email		

office address where patients are seen

address for directory

PRACTICE ADDRESS ☐ Same as above		
Group practice name as it appears on SS4 or W-9 form		
Address	Suite	City, state, ZIP
Telephone		Fax
Office email		

Cross coverage (list covering providers)

Do you have arrangement for 24 hour, 7 day a week medical coverage for your patients? ▪ Yes ☐ No

If no, please explain _____

Name	Specialty	Address	Phone
Name	Specialty	Address	Phone
Name	Specialty	Address	Phone

Do you currently admit and care for your hopitalized patients? ▣ Yes ☐ No

If no, please explain the formal inpatient coverage arrangements you have for each inpatient facility _____

Consent and release:

I consent to the release of this information to the Council for Affordable Quality Healthcare (CAQH), for the purpose of allowing Priority Health access to my information in the CAQH Universal Credentialing DataSource (UCD).

By signing this pre-application, I affirm that the information I have supplied is correct and complete and that any misstatements in or omissions from this pre-application may be cause for denial of credentialing.

Name (Please print) _____

Physician/Physician Representative signature_____ Date_____

Attach:

▣ W-9 Form

☐ Sample completed HCFA 1500 claim form (blackout patient info)

Email to ***PH-PELC@priorityhealth.com*** or fax to 616.975.8857

Form **W-9**
(Rev. August 2013)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

☐ Other (see instructions) ▶

Exemptions (see instructions):
Exempt payee code (if any) _____
Exemption from FATCA reporting code (if any) _____

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
☐☐☐ – ☐☐ – ☐☐☐☐

Employer identification number
☐☐ – ☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here | **Signature of U.S. person** ▶ | **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. The IRS has created a page on IRS.gov for information about Form W-9, at *www.irs.gov/w9*. Information about any future developments affecting Form W-9 (such as legislation enacted after we release it) will be posted on that page.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, payments made to you in settlement of payment card and third party network transactions, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.